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**WAIT A MINUTE**

**I DIDN'T SIGN UP FOR THIS!**

by

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In Partial Fulfillment of the Graduation Requirements

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## *Preface*

Personal experiences, and what I felt to be inadequate answers from the Judge Advocates' office in my Reserve wing, prompted me to look more deeply into the impact that the post-cold war environment had on aeromedical evacuation (AE) crewmembers. I am deeply concerned about the issues facing AE crewmember as they are sent on deployments for MOOTW. Are we as ready and prepared as the Air Force says we are? It is my contention that we are not as ready as many believe. AE crewmembers are not informed of the situation and circumstances that we may find ourselves in the future. Medical readiness training is insufficient training for the combat and hostile situations that we will face. Readiness is one of the pillars in the AFMS parthenon and is of major importance and concern to Lt. General Paul K. Carlton, the Surgeon General of the Air Force. It is very important that every AE crewmember be 100% ready to execute their vital responsibilities.

I wish to extend my appreciation to the following individuals who have assisted and provided necessary guidance on this paper. Major Marlin Moore, Mr. Darrell Phillips of the JAG office, the HRA at Maxwell AFB, AL., and Chief Master Sergeant Jan Murphy, AFRC.

### *Abstract*

When the medical non-combatant is denied security, safety, and rights under the Law of Armed Conflict and Geneva Convention, this tendency toward anarchy in warfare suggest that there is safety for no one. Medical non-combatants are not trained or prepared to be Prisoners of War. Medical non-combatants are not prepared or ready to face the human rights violations common to third world prisons that some Prisoners of War have endured. When both State and non-State actors disregard the legal status of medical non-combatants, these individuals face an increased danger that they may not fully understand. The increasingly common employment of dual mission aircraft lends to further confusion of the medical non-combatant status. Emerging trends in the aeromedical evacuation (AE) system suggest that by 2010 a preponderance of aeromedical crewmembers will lack sufficient training to execute their readiness mission capabilities. This paper analyzes and discusses the challenging factors facing the AE crew in the post cold war environment and the impact of those factors have on their readiness.

## Part 1

### Background

*The principle that the wounded and those who care for them in time of war should enjoy a protected status has been a constant of the law of warfare since the Peloponnesian War.*

—Jean Guillermand

**Vietnam.** On December 2, 1967, while flying a mission from Chu Lai to LZ Two Bits, Vietnam, Dr. Hal Kushner of the 1/9Cav, 1 Cavalry Division, was taken prisoner after his helicopter was shot down. During the next five and a half years, the North Vietnamese held him as a Prisoner of War (POW). He remembers, “While in basic training and my Escape and Evasion course, they told us that, as Doctors, we didn’t have to worry about being captured. Doctors and nurses, they said, were not POWs, they were detained under the Geneva Convention. If they treated us as POWs, we should show our Geneva Convention cards and leave.” Upon being captured he recounts, “I showed my captor my Geneva Convention card, white with a red cross. He tore it up. They tied me with commo wire in a duck wing position, took my boots and marched me mostly at night for about 30 days.” He was moved from camp to camp and finally ended up in the Hanoi Hilton. During his tenure as a POW, he was denied medical treatment, brutally beaten, abused, starved, refused the right to treat injured or ill soldiers, and denied all rights prescribed under the Geneva Convention (GC) and Laws of Armed Conflict (LOAC) for a medical non-combatant.<sup>1</sup>

**Desert Storm.** On February 2, 1991, while flying over Iraq, Major Rhonda Cornum, a flight surgeon was on a search and rescue mission for a downed F-16 pilot, when the Black Hawk she was riding in was shot down. Major Cornum was badly injured, suffering from two broken arms, a bullet wound to her shoulder, and one badly injured leg. A POW, she was denied medical treatment for days and was not released immediately as a result of her injuries, which rendered her incapable of providing medical care to other prisoners of war. She states, “I did occasionally imagine having to kill another human being, but my job was to save lives, not take them. As medical people, we were allowed to defend ourselves but we were not supposed to engage the enemy. ...The trouble with ‘rules of war’ is that they only work if both sides abide by them.”<sup>2</sup> A few short hours after her capture she recalls thinking, “Technically, medical personnel are not supposed to be made prisoners of war. The Geneva Convention states that doctors are to be returned to their side unless they are caring for soldiers from their units who also are prisoners. Pilots in the Air Force, Navy, and Marines, as well as special operations, are given entire courses on what to do if they are shot down, what they can say and what they should not say...known as Survival, Evasion, Resistance, and Escape (SERE).... What I knew about being a prisoner of war came from old war movies, give only your name, rank, and serial number.”<sup>3</sup>

**Thesis.** When the medical non-combatant is denied security, safety, and rights under the Law of Armed Conflict and Geneva Convention, there is safety for no one, combatants and non-combatants alike. Are medical non-combatants prepared and ready to be subjected to treatment as a Prisoner of War? The thesis of this paper that they are not ready or prepared due to a lack of education and training. This situation is further complicated by the nascent state of AE doctrine. Are medical non-combatants prepared and ready to face the violations physical and otherwise

that some Prisoners of War have faced? An historical lack of regard for the authority of law and for the rights of the medical non-combatants' status clearly demonstrates the potential danger that an aeromedical crewmember can face. These threats are exacerbated by current AF doctrine, that position combatants and evacuation medical evacuation personnel on aircraft with dual mission responsibilities. Aeromedical crewmembers are currently unprepared for their mission responsibilities and without immediate action this will become a growing problem through 2010. Support for the thesis is drawn from multiple sources: 1) a critical review of the Law of Armed Conflict (LOAC); 2) an examination of the current strategic environment, which serves as the backdrop for modern day contingency operations; 3) an evaluation of the emerging demographics of the nursing and medical services; and 4) an historical review of the evolution of the aeromedical evacuation system.

## **Law of Armed Conflict**

The law of armed conflict, also known, as the law of war, is “that part of international law that regulates the conduct of armed hostilities.”<sup>4</sup> It is broken down into two overlapping areas and defines how war is conducted. The first area, the Hague law, is concerned mainly with the means and methods of warfare.<sup>5</sup> The second area is the Geneva law, which was set up to address the issues of protecting people and victims of conflicts (whether combatants fighting on land, sea, or air, POWs, or military non-combatants and civilians).<sup>6</sup>

Under the Geneva Convention, Common article 2 references the LOAC as applicable in any international armed conflict regardless of whether war has been declared.<sup>7</sup> The LOAC does not recognize situations where there are internal disturbances or riots, where there may be no recognized government, or where there is an absence of an international conflict, as was the case in Somalia, Rwanda, and Haiti. The Geneva Conventions of 1949 did not apply to these

situations as they fail to qualify as “international armed conflicts.”<sup>8</sup> Forces employed in UN peace operation are under the 1946 conventions on Privileges and Immunities of the United Nation and are protected under this authority as “experts on mission.”<sup>9</sup> This 1946 convention requires that when an “expert on mission” is captured, he or she must be released immediately.

**Source Material.** The current body of law that defines and provides for the protection of the medical non-combatant and medical assets is outlined in three primary sources: The Geneva Conventions,<sup>10</sup> AF Pamphlet 169-10,<sup>11</sup> and Air Force Regulations.<sup>12</sup> These sources identify the responsibilities and obligations owed to those who render medical care to the sick and wounded, and also details the duties and responsibilities of the medical provider to support the sick and wounded under their care.

In Air Force Regulation 160-4, paragraph 1d, “medical services” is defined as:

- 1) seeking, collecting, transporting, treating, or sheltering wounded or sick personnel of the armed forces;
- 2) engaging in activities designed to prevent or limit the spread of disease to or among personnel of the armed forces;
- 3) Administering the personnel or facilities engaged in the activities described in (1) or (2) above.<sup>13</sup>

One must be engaged in the duties of the medical service to warrant protection under the Geneva Convention as a medical non-combatant. Medical personal have a professional duty and take an oath to render medical care to the sick and wounded. To be denied this right and obligation to render medical care is considered a violation of the Geneva Convention. Major Bruce Smith, in his article,<sup>14</sup> speaks of the importance of determining whether an individual is permanently or temporarily assigned to medical duties and understanding the rational for why

they must not be given assigned duties incompatible with medical services. Performing incompatible duties (e.g. offensive warfare) would render their protected status null and void. AFR 160-4 and the Geneva Convention on the wounded and sick also characterize the distinction of “permanent” medical personnel as military forces, whose country recognizes and supports the Geneva Convention, who are engaged in and train for medical service, and are providing such medical care.<sup>15</sup> The scope of this paper is limited to a consideration of the aeromedical crewmembers that are assigned to provide medical services, because they are most likely to overfly hostile territory and to be transported on “dual mission” aircraft. The status of other medical non-combatants will not addressed.

**Aeromedical Aircraft.** Due to the nature of the role of the aeromedical evacuation medical crewmember to provide medical care to the sick and wounded in the air, a brief discussion of the aircraft status is indicated. Articles 24-30 of the Geneva Convention provides a lengthy discussion of the protection afforded the medical aircraft, which can be summarized into the identification and responsibilities of such aircraft.<sup>16</sup> Three features identify aircraft assigned to fly medical missions; a distinctive red cross on the lower, upper, and lateral surfaces; a visible flashing blue light; and distinctive radio signals followed by a radio message.<sup>17</sup>

Aircraft commanders have certain responsibilities when overflying an area physically controlled by an adversary. For example, an aircraft must obey a summons by the opposing forces to land in enemy territory.<sup>18</sup> This requirement is outlined in Article 27 of the Geneva Convention paragraph 1, “The medical aircraft of a Party to the conflict shall continue to be protected while flying over land or sea areas physically controlled by an adverse party, provided that prior agreement to such flights has been obtained from the competent authority of that

adverse party.”<sup>19</sup> When non-state actors are involved, attempting to determine who is the “competent authority” can prove to be a difficult problem.

The opposing force also has the right to board and physically inspect the aircraft contents.<sup>20</sup> If found to be in accord with the provisions of the Geneva Convention, the aircraft should be allowed to proceed with its flight without delay.<sup>21</sup> If the aircraft is in violation then all occupants should be appropriately treated in accordance with their respective Geneva Convention status.<sup>22</sup>

What criteria are used to determine whether there has been a violation by an aeromedical mission? Article 28, paragraph 1 reads, “The parties to the conflict are prohibited from using their medical aircraft to attempt to acquire any military advantage over an adverse party. The presence of medical aircraft shall not be used in an attempt to render military objectives immune from attack.”<sup>23</sup> Paragraph 3 goes on to state, “Medical aircraft shall not carry any armament except small arms and ammunition taken from the wounded, sick and shipwrecked on board and not yet handed to the proper service, and such light individual weapons as may be necessary to enable the medical personnel on board to defend themselves and the wounded, sick and shipwrecked in their charge.”<sup>24</sup>

Paragraph 1 indicates that aircraft used for any purposes other than to transport medical patients during that flight would lose its protected status and forfeit the corresponding rights to protection. Should warfighting assets be on board during a medical mission that is inspected, the United States position would likely be that this would not have been done deliberately or to gain an advantage. However, would the adversary always accept the word of the United States if they felt deception was involved? Paragraph 3, is somewhat vague about what constitutes “small arms and ammunition.” If the “dual mission” aircraft is carrying combatant military members,

high caliber or advanced weapons, or equipment for warfighting, who determines the status of the aircraft?

Paragraph 3 of Article 28 speaks of the types of equipment that is recognized as appropriate to be on a medical mission, such as to support the medical patients. It states that a medical aircraft cannot collect, transmit, or carry any equipment intended for purposes of intelligence gathering. Article 8, subparagraph (f) continues to define what is prohibited regarding personnel and cargo on such missions.<sup>25</sup> However the equipment required by the aircraft to navigate, communicate, and used for identification are not prohibited. It should be noted that if an aircraft is directed to land on territory belonging to the adversary, and after being inspected, is deemed to be in violation of their medical mission, all medical personnel would lose their protected, non-combatant status. Depending on the adversary and situation, they could be classified as prisoners of war or as a civilian protected under the Fourth Convention based on nationality.<sup>26</sup>

In summary, the Geneva Convention and LOAC address many of the concerns faced by the aeromedical crewmember in regards to their protected status whether on the ground or in the air. It defines the expectations and limitations of the aircrafts' role with regards to aeromedical evacuation. It is now dependent upon the US and the adversarial actors and states involved to decide whether they will follow LOAC and Geneva Convention guidance or risk forfeiture of the protected status of their aeromedical assets. The U.S. must ensure that the aeromedical evacuation crewmembers are educated and reasonably informed of all legal and environmental factors that influence their circle of safety and protection.

## **Recent Changes in the Strategic Environment**

In today's post cold war environment, the military faces many challenges to its mission. Some missions have disappeared, for example, the defense of Europe from a Soviet ground

attack. Others have been added, such as peacekeeping and humanitarian missions in Eastern Europe. During the Cold War, the greatest threat was of nuclear or conventional war with the Soviet Union (USSR). Maintaining a balance of power between the two superpowers was essential for national security. With the fall of the Berlin Wall and USSR, the United States now faces different threats. A few of these include: non-state actors, (regional or state-centered and transnational); the spread of dangerous technologies; failed states; the increasing threat of biological warfare; and information attacks.<sup>27</sup>

After World War II and through the Cold War years the military strategy of the United States was to maintain a forward-deployed, permanent military presence in overseas locations. Drawing down U.S. military forces, the changing international environment and the size of the US permanent overseas presence has all markedly decreased since the end of the Cold War.<sup>28</sup> However, the U.S. still needs a permanent forward presence. For national security strategy reasons to fulfill both temporary and long-term missions the U.S. will still need the capability to deploy military forces abroad quickly.<sup>29</sup>

In recent years, U.S. military forces have found themselves involved in several MOOTW, serving in peacekeeping, peace enforcement, peacemaking, peace operations, and humanitarian and disaster relief roles.<sup>30</sup> These are not the traditional roles of the military for which they train to fight, defend, and protect the National Security and National Military Security Strategies. The increasing complexity of mission now undertaken by the U.S. military is illustrated by recent missions in Somalia, Haiti, and Bosnia. Not only is the military tasked with maintaining its' ability to execute traditional functions and roles, but it is also now forced to adapt to newer, non-traditional roles, and missions.

The post cold war environment now includes many types of war or what some would define as international conflicts. Papp believes future international conflicts will range from international crisis, low-intensity conflicts, terrorism, and civil and revolutionary wars, through international wars.<sup>31</sup> International crisis, low intensity conflict, terrorism, civil and revolutionary wars are less likely to follow the LOAC and are more likely to involve non-state actors. Why is this relevant?

The state actor is considered a sovereign authority, a territory, a population, and is recognized as a state by the authorities of other states.<sup>32</sup> This means the state actor is accountable to international law and norms in warfighting. In other words, they are expected to uphold the standards of moral conduct or to be punished for criminal actions or non-adherence to these standards. Historically, some state actors have not followed international law (as experienced by Dr. Kushner during the Vietnam War and Dr. Cornum in the Gulf War).

Dr. Muller classifies non-state actors as transnational, international, and ethnic group actors.<sup>33</sup> Legal authorities contend that non-state actors are obligated (accountable) to uphold the same international law and norms as the state actors. Unfortunately, this may not always be the case. The transnational and ethnic groups that are so often involved in crises and conflict are not directly accountable to any state or legal entity that governs their actions or behaviors. Thus, they act as rogue entities and ignore or defy these agencies in pursuit of their own agenda or gain.

To illustrate only one example of a contemporary problem, consider the large Islamic population in Southwest Asia. Many of the Islamic fundamentalists and Muslims view Westerners as outsiders and unholy (i.e., Westerners soil their lands and countries with their presence). Their views of life and its importance are based on *jihad*, “striving in the path of the

one god” in defense of the *ummah*.<sup>34</sup> To die in defense of the *ummah* will not only absolve one of his sins, but will assure immediate entry into paradise. These types of beliefs are quite different than those held by Westerners who adhere to a Judeo-Christian value system. For some non-state actors, there is greater honor in death than in life and they have contempt for those who do not share their beliefs. When AE crewmembers are captured by groups adhering to these beliefs, how will they be treated? This question can’t be answered definitively, but history suggests ways that AE crewmembers might best be prepared for such an event.

Just as the dynamic strategic environment presents new challenges for U.S. military forces, the restructuring in the medical services has created new demands for patient care providers. Along with the restructuring, the old practice of giving complete and total patient care ranging from the minor illness and injury to major trauma and critical illness has been replaced by a more dynamic treatment process that better meets the requirements of a new era.

## **Emerging Medical Demographics**

**Facilities.** Since the mid 1990’s the Air Force and other service branches have been experiencing a rebirth and structuring of medical services. Instead of employing the old military system of providing health care to military members, dependents, and retirees, these services are increasingly contracted out to civilian health care providers. Most military bases used to have hospitals that provided the full spectrum of patient services ranging from inpatient care to routine and urgent outpatient services. Included in these services was the aeromedical airlift of patients to locations that provided specialized care and treatment. Currently, many of the full spectrum hospitals are being reduced to outpatient clinics, some of which provide outpatient surgical services. The patients requiring treatment for specific diseases are referred to civilian specialists

(e.g., cardiology, endocrinology, orthopedics, and neurology). In peacetime, little to no aeromedical airlift is performed due to the utilization of local community resources.

**Staffing.** Along with the drawdown and reduction in medical services and personnel, medical readiness training once gained from providing many of the services in a full spectrum hospital are now lost. Nursing and medical staffs are treating routine and non-emergency medical diseases or illnesses, instead of the medical intensity of diseases and injuries they will be faced with in a major contingency or wartime scenario.

The turnover rate of active duty nursing personnel has averaged 11% per year since 1991.<sup>35</sup> The median length of service is just slightly over six years.<sup>36</sup> This suggests that approximately every six years 66% of the nursing staff has turned over. If this trend continues, by 2005 the entire junior nursing staff will have been replaced since Desert Shield/Storm. This level of turnover implies that the current nursing personnel will have little or no military medical experience to prepare them for the major trauma, injuries, and acute illnesses that occur in foreign deployed locations. Similarly, the active duty nurse will have had little or no experience in aeromedical transport.

Today, as opposed to the past, only active duty nurses and medical technicians with a definite AE assignment attend flight school training. Currently there are six flight school courses per year to train nurses and technicians.<sup>37</sup> Each class has 50 students; half are nurses and half are medical technicians. Of the nurses, 10 are Active Duty with assignments to go to one of three locations: Scott, Yokota, or Ramstein.<sup>38</sup> These nurses serve a two or three year tour as an aeromedical crewmember during their career. This means less than two percent of the active duty nursing staff is trained every year and thereby gains experience in aeromedical transport.

Fewer than four percent of the active duty nursing force are assigned to aeromedical evacuation billets each year.

There is an upside to this, in that as a Total Force concept, the Air Force Reserve Aeromedical Evacuation Squadrons are continually trained and ready to meet a wartime contingency mission. The Air Force Reserves flew 92% of aeromedical missions worldwide in 1999.<sup>39</sup> As the active duty side of the house continues to draw down the percentage of aeromedical evacuation mission requirements for the reserves will increase. This would indicate that there will be and are fewer active duty aeromedical missions and assignments.

## **The Evolution of Aeromedical Evacuation**

The Surgeon General's publication of "*A Concise History of the USAF Aeromedical Evacuation System*"<sup>40</sup> chronicles the evolution of AE doctrine and practice. Aeromedical Evacuation (AE) has been employed in every war and conflict since 1870. During the Franco-Prussian War of 1870, 66 balloons carried 160 sick and wounded soldiers to safety. Aeromedical Evacuation is no stranger to the realm of conflict and has been called upon to serve during every war and conflict since its beginnings. The world's first ambulance airplane was constructed with a test flight in 1910. It reached an altitude of 100 feet and flew 500 yards before an oil line ruptured and caused it to crash. The first attempts and later successes demonstrated that aeromedical evacuation could promptly respond to the needs of the injured and wounded soldier.

**WWI.** In 1915, thirteen men wounded in Serbia were transported from the front to receive medical care. In 1918, at Flanders, in WWI, the first actual evacuation of wounded military personnel by aeroplanes specifically equipped for aeromedical evacuation was successfully accomplished. The United States used airplanes for evacuating wounded from the battlefield

during WWI, but sparingly due to the perceived notion the need for aerovac didn't exist and a practical airplane was not available. Using an ambulance plane, a doctor could fly to an injured pilot, treat him immediately, then if required, have the patient flown out for hospitalization.

During the years between WWI and WWII the Army Air Service designed, built and converted aircraft to meet future aeromedical mission requirements. Carrying more than two patients and allowing for medical personnel to accompany the patient from point of origination to destination increased the probability of survival by providing for continuity of care.

**WWII.** At the beginning of WWII, many military authorities believed that air evacuation of patients was dangerous, medically unsound, and militarily impossible. In 1941, after the AF was designated as a separate service, David Grant became the first air surgeon. His proposals to use air evacuation were met with much opposition from the upper echelons of the Army, especially the Surgeon General. Notwithstanding, his request to form an aeromedical evacuation program was approved in June 1942. He believed that specially trained medical personnel must accompany the wounded while flying because there were not enough physicians available to put one on every flight. In February 1943, the first class of flight nurses graduated. In addition to medical personnel, a fully equipped ground hospital to care for the sick and wounded during flight and stopovers was co-located at airstrips.

In 1943, approximately 173,5000 wounded and sick personnel were transported from overseas to the US via the new aeromedical evacuation system. During the years of 1944 to the end of 1945, the aeromedical evacuation system moved 1,000,000 patients, dispelling any previous doubts about the value of aeromedical evacuation. To further substantiate the value and importance of aeromedical evacuation, statistics indicate that in WWI, the death rate of wounded men who lived long enough to see a doctor was 8.5 per cent. This was halved in WWII when

only 4.5 percent of the wounded died. General Dwight D. Eisenhower was a strong supporter of air evacuation. Nearly 350,000 wounded were transported between D-Day and VE-Day. He later observed, “We evacuated almost everyone from our forward hospitals by air, and it has unquestionably saved hundreds of lives – thousands of lives.”<sup>41</sup> In September 1949, the Secretary of Defense declared that AE was to be the primary method of transporting military patients worldwide.

**Korea.** Aeromedical evacuation continued to be used throughout the Korean War to airlift sick and wounded soldiers to definitive care facilities and back to the US. With the increased numbers of patients and requests for AE came better utilization of cargo planes. They first dropped off cargo and then picked up patients for the return flight. This better utilized the aircraft and decreased the time required to get patients to medical treatment facilities. As different aircraft were utilized, some evidenced significant disadvantages, mainly in their ability to secure patients adequately for transport. On June 8, 1953 the 6481<sup>st</sup> Medical Air Evacuation Group was formed and given the additional manning and equipment required for the processing, temporary care, and staging of military casualties by air. The ability to provide rapid transport of the wounded led to a reduction of the death rate in the Korean War to half that of WWII.

During peacetime the mission of the aeromedical evacuation system was to airlift military members, their dependents, other US government employees, and our Allies with serious illnesses or accidents, from overseas locations to echelon IV CONUS facilities. The development of in-theater evacuation aircraft was implemented using such aircraft as the C-118 and C-121, which brought in supplies or passengers from the U.S. and then were converted to aeromedical evacuation planes for the return trip.

**Vietnam.** In 1964, the US entered the Vietnam War, and once again the aeromedical evacuation system found itself busier than ever. Services were provided throughout Southeast Asia and to the Far East Pacific Air Forces. Patients were airlifted from hospitals in Vietnam to bases in the Pacific, and then on to the United States. The rising casualty rate of the US Armed Forces was being felt with an unprecedented movement of patients from Southeast Asia. The Military Airlift Command (MAC) aeromedical evacuation system grew and adapted its operation to fit the current situations within the theater of operations.

In 1965, the introduction of the C-141 Starlifter transformed the aeromedical evacuation system with its ability to adapt to the AE mission. Patient in-transit time was significantly reduced after new movement routes were formed. A lesson learned from the Vietnam War was that many patients could not tolerate long distance travel. Thus, a dual staged aeromedical evacuation concept was initiated. Patients were transported from the combat zone to another base, treated, and stabilized. Once stabilized, they were returned to duty or transported to the US for long term treatment and care.

This dual system of aeromedical evacuation led to a new concept of two distinct services, that of Tactical Aeromedical Evacuation (within the combat zone) and Strategic Aeromedical Evacuation (serving the Pacific and U.S.). The National and Military objective was to provide the most economical and expedient means available to transport patients and casualties.

In August of 1968, the first dedicated aeromedical aircraft, the C-9 Nightingale was brought on line. It wasn't until 1975 that MAC became the single manager for airlift worldwide and all aeromedical assets were unified under the single management the 375<sup>th</sup> Aeromedical Airlift Wing at Scott AFB, IL.

Aeromedical evacuation has come a long way and since its unification, has been involved in all wars and contingencies since Vietnam, including the 1981 airlift of the Iranian hostages, the evacuation of university students from Grenada, and the marines from Beirut. AE missions have included; the 1986-1993 refugee airlift from Pakistan, 1989 Just Cause in Panama, 1990 Gulf War Crisis and into Desert Shield/Storm to include the POWs lifted after the cease-fire, 1991 Provide Comfort, 1992 Operation Restore Hope, 1994 Rwanda and Haiti crises, and the recent Bosnia and Kosovo Operations.<sup>42</sup>

**AE Doctrine.** AE continues to operate under doctrine based on practice as seen throughout its' evolutionary history, however official AE doctrine is still in draft. The aeromedical evacuation system has historically operated without the formal guidance of doctrine. It created doctrine out of a necessity to airlift patients to definitive care facilities. To accomplish its mission the AE system has relied upon AF regulations, instructions, guidance documents, and pamphlets.<sup>43</sup> The mission of AE has rested on the systems' ability to justify the need for dedicated aircraft and to have those aircraft available when needed. The AF Health Services has implemented new doctrine that is authoritative, but not directive.<sup>44</sup> AFDD 2-4.2 level doctrine is meant to assist the reader in understanding how AE is being done and not provide "the how-to's."<sup>45</sup> The "how-to's" are forthcoming in AE-Tactics, Techniques, and Procedures (TTP) that is currently being written.<sup>46</sup> Thus until this doctrine is official, the AE system will continue to operate as it has successfully done through the years

Today's airlift offers the advantages of speed, comfort, and safety over other modes of transportation, meeting the twin objectives of enhancing medical treatment and saving lives. Aeromedical personnel are ready and prepared to respond medically to any crisis, conflict, or war with the ability and capacity to render outstanding patient care efficiently and effectively.

However, it is unclear that the aeromedical personnel fully understand how changes in the post cold war strategic environment affect training needs and the overall readiness of medical personnel.

## Notes

<sup>1</sup> Dr. Hal Kushner, “A Very Personal Story of Vietnam”, given at the 1<sup>st</sup> Calvary reunion, in 1999. The full account is attached in Appendix B.

<sup>2</sup> Rhonda Cornum as told to Peter Copeland, *She Went to War, the Rhonda Cornum Story*, (Presidio, 1993), 39.

<sup>3</sup> Ibid, 47.

<sup>4</sup> W. Darrell Phillips, Chief, International and Operation Law, AF JAG School, Maxwell AFB, Ala. “Peace Operations: LOAC and ROE”, lecture to Capital University Law School, Columbus, OH, 18 September 1999.

<sup>5</sup> Ibid.

<sup>6</sup> Ibid.

<sup>7</sup> Jean S. Pictet, ed., Commentary: *Geneva Convention for the Amelioration of the Condition of the Wounded and Sick in the Armed Forces in the Field*, Common Article 2, ICRC (Geneva, 1952). [For future reference, the shorten book version is GWS-1949].

<sup>8</sup> Chairman JCS instruction, CJCSI, 3121.01 1 Oct 94, Enclosure A, Paragraph 1.i. [The United States will always comply with LOAC under the Standing Rules of Engagement for US Forces and it is a part of our national policy].

<sup>9</sup> *Convention on Privileges and Immunities of the United Nations* 13 Feb 1946, 21 U.S.T., 1418, T.I.A.S. No. 6900, 1 U. N. TS. 15, T.S. 993.

<sup>10</sup> Jean S. Pictet, ed., *GWS-1949, Commentary: Geneva Convention for the amelioration f the condition of wounded, Sick and Shipwrecked members of Armed forces at Sea (GWS-Sea 1949); Commentary: Geneva convention Relative to the Treatment of Prisoners of war (GPW-1949); Commentary: Relative to the Protection of Civilian Persons in Time of War (GC-1949)*; ICRC, Geneva (1952).

<sup>11</sup> Air Force Pamphlet (AFP) 169-10, *Law of Armed Conflict, Geneva Conventions, and Code of Conduct*, 5 January 1987.

<sup>12</sup> The Air Force mandate Judge Advocate responsibility for Law of Armed Conflict training in AFR 11-032. This regulation implements DOD Directive 5100.77, *Law of War Programs*, 9 December 1998, which established law of war training requirement for all branches of the military.

<sup>13</sup> Air Force Regulation (AFR) 160-4, *Medical Services under the 1949 Geneva Convention on Protection of War Victims*, 10 September 1971, para 1.d., (note this was rescinded by Air Force Index 2, 4 January 1994, which has deleted this entire regulation and it has not been replaced with a definition or description of what is medical services).

<sup>14</sup> Major Bruce T. Smith, ANG. “Air Force Medical Personnel and the Law of Armed Conflict”, *The Air Force Law Review*, Vol. 37, (Air Force Judge Advocate General School, Maxwell, AFB, AL, 1994), 239-251.

<sup>15</sup> AFR 160-4 and Pictet, ed., *GWS-1949*, Article 24, ICRC (Geneva, 1952).

## Notes

<sup>16</sup> Jean S. Pictet, ed., *Commentary on the Additional Protocol of 8 June 1977 to the Geneva Convention of 12 Aug 1949*, Articles 24-30, ICRC (Geneva, 1987) [AP-1977 will be the shortened book version].

<sup>17</sup> Jean S. Pictet, ed., *GWS-1949*, Article 36, ICRC (Geneva, 1952), Article 7 of Annex I, *Regulation Concerning Identification, Additional Protocol II to the Geneva Convention of 1949*, ICRC (Geneva, 1977), AP-1977, Article 36, ICRC (Geneva, 1987).

<sup>18</sup> Jean S. Pictet, ed., *GWS-1949*, Article 36, ICRC (1952) and AP-1977, Article 27 & 30, IRCR, (Geneva, 1987).

<sup>19</sup> Jean S. Pictet, ed., *GWS-1949*, Article 27, ICRC (Geneva 1952), p.293.

<sup>20</sup> Jean S. Pictet, ed., *GWS-1949*, Article 36, ICRC (Geneva, 1952) and AP-1977, Article 27 & 30, IRCR, (Geneva, 1987).

<sup>21</sup> Ibid.

<sup>22</sup> Ibid.

<sup>23</sup> Jean S. Pictet, ed., AP-1977, Article 28, ICRC, (Geneva, 1987), p. 300.

<sup>24</sup> Ibid.

<sup>25</sup> Ibid. Article 8.

<sup>26</sup> Jean S. Pictet, ed., *GPW-1949*, ICRC, (Geneva, 1952).

<sup>27</sup> The President of the United States, *A National Security Strategy for a New Century*, (December 1999), p.2-3.

<sup>28</sup> Joint Chiefs of Staff, *Joint Vision 2010*, (1996), p.8.

<sup>29</sup> Chairman of the Joint Chiefs of Staff, *National Military Strategy of the United States of America*. (1997), ii. p. 3.

<sup>30</sup> Joint Publication 3-07, *Joint Doctrine for Military Operations Other Than War*, (1995), p. III- 1-15.

<sup>31</sup> Daniel S. Papp, "Typologies of International Conflict," *Contemporary International Relations: Frameworks for Understanding*, 4<sup>th</sup> ed., Macmillan College Pub. Co. (1984), pp 573-581.

<sup>32</sup> John H. Herz, "Article 19, The Territorial State Revisited: Reflections on the Future of the Nation State," *Classical Readings of International Relations*, Harcourt Brace College Pub. (1994), pp 97-107.

<sup>33</sup> Dr. Richard Muller, "Actors and Typology of War," lecture, Air Command and Staff College, Maxwell Air Force Base, AL, 20 October 1999.

<sup>34</sup> Lewis B. Ware, "A Radical Islamist concept of conflict", *Terrorism National Security policy and the Homefront* (US Army War College 15 May 1995), 31-60.

<sup>35</sup> Major Alan Bartholomew, The Office of the Surgeon General, United States Air Force, interviewed by author, 8 February 2000.

<sup>36</sup> Ibid.

<sup>37</sup> Major Ann McQuade, USAFSAM, Aerospace Education and Training Department, Education Division, Contingency Operations Branch, Aeromedical Evacuation, interviewed by author, 4 February 2000.

<sup>38</sup> Ibid.

<sup>39</sup> Col. Melissa A. Rank, Air War College, Maxwell AFB, AL., interviewed by author, 17 February 2000.

## Notes

<sup>40</sup> The Department of the Air Force, The Office of the Surgeon General, *A Concise History of the USAF Aeromedical Evacuation System*, (Washington, D.C. August 1976), 1-28.

<sup>41</sup> Ibid., 11.

<sup>42</sup> Col. Judith Hanson, USAF, *30 Years of Aeromedical Evacuation History*, San Diego, CA: Naval Education & Training Professional Development & Technology, 1998, videocassette.

<sup>43</sup> Lt. Colonel Jackson Dobbins, HQ Air Force Doctrine Center, Chief Medical Integration Branch, interviewed by author 16 March 2000 and Air Force Doctrine (AFDD)2-4.2,*Health Services*, 13 November 1999, p 19-20.

<sup>44</sup> Ibid.

<sup>45</sup> Lt. Colonel Jackson Dobbins, HQ Air Force Doctrine Center, Chief Medical Integration Branch, interviewed by author 16 March 2000.

<sup>46</sup> Ibid.

## **Part 2**

### **Present and Future Paradigms**

*Our anchor's too big for our ship, so we're sittin' here tryin' to think. If we leave it behind we'll be lost. If we haul it on board, we will sink. If we sit and keep talkin' about it, it will soon be too late for our trip. It sure can be rough on a sailor when the anchor's too big for the ship.*

—Shel Silverstein

*It's too easy to say what about the just wars! There are thousands of people who will be happy to give you the justification you want. Just don't ask me to. I know what war is. And I will not forget.*

—Lynda Van Devanter Buckley

### **Readiness Assertion**

The medical service of the United States Air Force is in the process of dynamic change. The new AF Surgeon General, Lt Gen Paul K. Carlton Jr., introduced new concepts, programs, and changes driven by continuing budgetary constraints, a constantly changing strategic environment, and Joint Vision 2010.<sup>1</sup> Readiness is one of the pillars in the Air Force Medical Service (AFMS) parthanon (see Appendix A) and a core competency.<sup>2</sup> Aeromedical Evacuation crewmembers should be 100% ready in every capacity. Lt Gen Carlton has set forth AFMS goals under each of the pillars to provide direction for the medical service in their quest to be prepared for the future.<sup>3</sup> The fourth goal of the AFMS under the pillar of Building Healthy Communities (emphasis on intervention and prevention) is “Optimize Health, Safety and

Performance.” One of the stated objectives of this goal is: “Enhances support to aerospace operations—Occupational support of aircrew includes fact-based determinations of fitness for flying duties and strategies for performance enhancement and force protection.”<sup>4</sup> Force protection not only applies to medically protecting Air Force personnel, but also to the medical non-combatants’ individual mental and physical protection. For the AE crewmembers to be ready in every capacity requires they employ prevention and force protection to overcome the emerging threats of today.

Since the end of the Cold War, the U.S. military has undertaken new roles and now works more closely with coalition forces in joint operations. The shrinking military budget forces the Air Force to re-evaluate its roles and missions, and to find creative ways to accomplish taskings in a more economical manner. Lt.Gen Carlton’s vision and implementation of Critical Care Air Transport Teams (CCATT) and his Mobile Field Surgical Teams (MFST) are two new approaches whereby medical services meet the dynamic changes and challenges of new roles.<sup>5</sup> These teams are staffed according to the medical skills and expertise they bring to the fight and receive no flight school training. Many of the same LOAC related challenges faced by the AE crews may become problems for these new, forward-deployed teams as well. The need for readiness training has never been more urgent than now. The challenge for future force readiness is to be informed and prepared to meet the potential dangers of today. As the threats from non-state actors and asymmetrical warfare grow, the requirement for increased education increases.

## **Doctrine**

The lack of doctrine for aeromedical evacuation has not presented a great problem for the AE community until the reduction in available airframes designated or redesignated for AE

missions. Changes in the structure of the AFMKS have exacerbated these effects, as discussed previously in the evolution of aeromedical evacuation section. The availability of aircraft designated or redesignated for AE missions increased between WWI and Vietnam, so the paucity of AE doctrine was less of a factor. The support of the AE mission to provide medical care in the air and increase the survivability of the military combatant reflects the current goal of reducing the number of American casualties. Successful operations have resulted, in part, from the guidelines in AF regulations, instructions, and pamphlets at a tactical level. Now however, with the reduction of designated or redesignated AE aircraft, AE crewmembers lack appropriate training in the use of opportune aircraft or in the changes created by a new strategic environment.

Operational doctrine and tactical procedures can have a significant impact on the readiness of AE crewmembers. This has a major effect on their training and subsequent degree of force protection. The ability to effectively perform AE duties and responsibilities in a safe environment will require that doctrine adequately incorporate the ramifications of a changing strategic environment.

In summary, the reduction in the designated AE aircraft inventory and lack of current doctrine creates a situation of increased risk for the crews, patients, and the AE mission. While using opportune aircraft solves the problems associated with the loss of a dedicated or designated AE fleet, it creates other force protection, LOAC, and Geneva Convention related problems.

## **LOAC and Opportune Aircraft**

In the post-Cold War military drawdown, aeromedical crewmembers are now being tasked to fly missions on any opportune aircraft.<sup>6</sup> With the increased OPSTEMPO including more MOOTW, the medical non-combatant is often faced with challenges and situations normally encountered by combatants. The Law of Armed Conflict and Geneva Convention annual

training prepares the medical non-combatant for the textbook scenario of a war between state actors. However, as the United States and its Allies are pulled into more MOOTW situations involving non-states actor and failed states, the fog and friction of the situation turns the black and white textbook scenario to gray.

**Dedicated aircraft.** This blurring of the non-combatant roles is an unintended consequence of the recent changes and restructuring of both the AE system and how medical services are provided. Until recently aeromedical missions have been accomplished using designated C-9s or reconfigured C-130 Hercules and C-141B Starlifter aircraft.<sup>7</sup> In 1994, AFI 11-2AE officially introduced the use of “opportunistic” or other available aircraft for aeromedical evacuation missions. This affords a temporary certification for AE crewmembers versus qualification on a specific aircraft.<sup>8</sup>

Restructuring of the AE system and regulations specifying the use of opportune aircraft for AE missions has created a series of potential problems for the medical crew on board. The first problem rests with the C-141 deletion from active duty inventory by 2002 and reserve inventory by 2005.<sup>9</sup> Also, the expected elimination of the C-9 from CONUS inventory will leave no specifically designated aircraft to replace both aircraft for AE missions.<sup>10</sup> This is compounded by the TriCare contracts and local civilian contracted providers and hospitals. Therefore, it is more economically feasible to purchase care for special medical requirements in the local community than to fly the patient to another military facility across the country. This leads to the use of opportune aircraft availability for AE missions, such as the C-21 and other aircraft being used for priority and urgent missions. Such aircraft however, have the capacity of transporting smaller patient numbers than the C-9 or C-141.<sup>11</sup> To supplement the military aircraft the Air

Force has a contract with civilian commercial airlines known as the Civil Reserve Air Fleet (CRAF) to provide airframes for AE airlift.<sup>12</sup>

**Opportune Aircraft.** Any “opportunistic” aircraft in the vicinity of a wounded casualty can be used for AE missions.<sup>13</sup> This could include aircraft with a “wartime” mission, which carry warfighting assets, materials, and personnel on board. Such an action would negate the protected status of the AE crewmember as discussed under the LOAC and Geneva Convention. Unless educated and trained on doctrine and implication of use of opportune aircraft, the AE crewmember will have little situational awareness or preparation to understand how they might lose their protected status.

Another potential problem that arises from the increased use of opportune aircraft is the lack of Geneva Convention mandated designators for identification of aeromedical aircraft. In today’s changing strategic environment, it is highly likely that non-state, or poorly trained state actors would not know the designators or identifiers of AE aircraft, nor would they have the capability to establish radio contact. It may also be difficult to identify and contact the authority that would negotiate appropriate overflight zones for the non-international armed conflict.

In a real world scenario, would the aircraft commander of an opportune aircraft adhere to demands of the adversary to land the aircraft for inspection? In fact, aircraft commanders may actually lack the necessary training and understanding of the Geneva Convention governing AE missions and adversarial requests for landing and inspection. This is yet another example of how the protected status of the AE crewmember might be at risk. AE training does not currently prepare crews to deal with the actions and irrational behaviors of transnational or non-state actors.

As the dedicated medical evacuation fleet shrinks, the probability increases that AE crewmembers will be faced with challenges created by the use of opportune aircraft. AE crewmembers are currently transporting patients on helicopters, gunships, small fixed winged aircraft, and jets. The aircraft are not U.S. assets, but also belong to our allies, (e.g., as seen in Somalia.)<sup>14</sup>

**Somalia.** In Somalia, local “thugs” attacked the Swedish and American Hospitals with gunfire, totally ignoring the red cross designations on tents or the red cross patches on the arms of medical providers. Italian helicopter gunships arrived to transport wounded NATO forces and their attending U.S. AE crewmembers. Even though the gunships landed on the internationally recognized white circle with a red cross and they were fired upon. This was a peacekeeping mission involving non-state actors.<sup>15</sup> Because it was categorized as a non-international armed conflict, the Geneva Convention did not apply. This is precisely the type of scenario that illustrates the complexities created by the use of opportune aircraft in the context of a rapidly changing strategic environment.

## **Training and Education**

Education and training of AE crewmembers are the core elements needed to establish 100% readiness to face the challenges of today and the future. Flight school exists to enhance AE crew readiness, although it fails to provide all-inclusive training in the survival, evasion, rescue, and escape (SERE).<sup>16</sup> Since 1998, flight school began offering six days of combat survival training, expanded from four days in previous years.<sup>17</sup> These six days include four days in the field with survival instruction, including water survival and rescue. The two additional days are dedicated to escape and evasion training. No training is given in resistance including preparation for treatment as a prisoner of war. The Air Force Medical Service (AFMS) has no plan to provide

the two days of additional training to AE crewmembers that attended flight school prior to 1998.<sup>18</sup>

SERE training is of significance and importance to reservists especially, as most may spend their entire air force career flying. The responsibility to provide SERE lies with the individual squadrons who determine how they will accomplish it, in conjunction with the life support squadron. Thus, there is no consistency or uniformity from squadron to squadron on training schedules or standards of implementation.

For AE crewmembers to get SERE training, the operations group commander and AE commander must concur. Life support must schedule the person and funding must be available. The belief of these individuals drives how important this training will be to readiness and survival of AE crews, not only physically, but also morally, spiritually, mentally, and ethically. The crewmembers who receive resistance training and posses a working knowledge of what to expect, are much better prepared to utilize SERE. Crewmembers who receive only a medical non-combatant indoctrination rather than active training of the AF survival school (Fairchild AFB, WA) possess a lower (and probably, inadequate) level of readiness.

### **Counter-argument**

For the reasons that would justify additional SERE training for the AE crewmembers, there are also reasons against it. These arguments focus around the additional cost of training AE crewmembers. Specific issues include whether AE crewmembers would be sent to Fairchild, whether the current Flight School curriculum should be expanded to address all aspects of SERE, or whether trainers could be sent to the units to provide the additional training. Cost analysis would include such items as program development and implementation, costs of training equipment, travel costs, and TDY expenses. This would coincide with the fact that the AE

community is small in number and historically there have been few publicized incidents in which medical non-combatants have been prisoners of war. Given the trauma recounted by Drs. Kushner and Cornum, DOD faces hard choices in weighing the cost of incrementally increased training against the consequences of putting poorly trained medics in harm's way.

## **Closing Remarks**

The risk and vulnerabilities of AE readiness lie in examining the changes that have occurred; in doctrine and practice, the changing environment of the post Cold War, and the actors and typology of war. All of these suggest an increased likelihood that AE crewmembers being confronted by the adversary, challenging their "protected status". What would it take for the media or public opinion to sway the Air Force to provide SERE training thus increasing a measure of force protection? Is the cost of not providing comprehensive training worth the vulnerability and risk of being put before the scrutiny of family members, public, and media?

The AE crewmember needs to be prepared in the particulars of LOAC and the Geneva Convention, what constitutes a detainee, what the laws dictate should be your responses and actions, but to the big picture scenario. Who are we fighting? What are their beliefs? Can we expect them to play by the same rulebook that the U.S. employs? What happens when the non-state actor makes his own rules as he goes along? Is the nature of the conflict such that LOAC and GC are applicable and recognized? Are the issues of mental and physical force protection being provided at all levels preparing the medical non-combatant for the asymmetric warfare of the present and future? The difficulty in answering each of these questions and others, show the need for the AE crewmember to be well read in all aspects of their mission.

## Notes

<sup>1</sup> Internet Resource: The Office of the Surgeon General of the United States homepage  
<http://sg.www.satx.disa.mil/af/sg/presentations/presentations.htm>.

<sup>2</sup> Ibid.

<sup>3</sup> Internet Resource: The Office of the Surgeon General of the Untied States homepage  
<http://sg.www.satx.disa.mil/ccx/sggoals/goal4/goal4.htm>.

<sup>4</sup> Ibid.

<sup>5</sup> Internet Resource: The Office of the Surgeon General of the United States homepage  
<http://sg.www.satx.disa.mil/af/sg/presentations/presentations.htm>.

<sup>6</sup> Air Force Instruction (AFI) 11-2AE vol. 1, *Flying Operations AE Aircrew Training*. Chapter 5, Aeromedical Evacuation Crewmember, Aircraft Certification Training Program, para 5.2 & 5.3.

<sup>7</sup> Lt. Colonel Susan Milovich, 22<sup>nd</sup> Air Force, Chief, Aeromedical Operations, interviewed by author 8 February 2000.

<sup>8</sup> Air Force Instruction (AFI) 11-2AE vol. 1, *Flying Operations AE Aircrew Training*. Chapter 5, Aeromedical Evacuation Crewmember, Aircraft Certification Training Program, para 5.2 & 5.3.

<sup>9</sup> Lt. Colonel Susan Milovich, 22<sup>nd</sup> Air Force, Chief, Aeromedical Operations, interviewed by author 8 February 2000.

<sup>10</sup> Ibid.

<sup>11</sup> Ibid.

<sup>12</sup> Air Force Doctrine (AFDD)2-4.2,*Health Services*, 13 November 1999, p 20.

<sup>13</sup> Air Force Instruction (AFI) 11-2AE vol. 1, *Flying Operations AE Aircrew Training*. Chapter 5, Aeromedical Evacuation crewmember, aircraft certification training program para 5.2 & 5.3.

<sup>14</sup> Major Martha Soper, USAFR, Nurse Corp, 22<sup>nd</sup> AF/DOV, interviewed by author 15 February 2000. (Maj Soper served in Somalia from May – August 1993 as a flight nurse out of Westover AFB, MA.)

<sup>15</sup> Ibid.

<sup>16</sup> Major Ann McQuade, USAFSAM, Aerospace Education and Training Department, Education Division, Contingency Operations Branch, Aeromedical Evacuation, interviewed by author 4 February 2000. (This is additional information: The active duty nurses and medical technicians with an AE assignment will always attend. Nurses who are members of a reserve AE squadron are required to attend and pass the course within a year of being assigned to the squadron. It could be years before reserve medical technicians attend, because their training can occur at the squadron level and there is no time requirement for them to attend.)

<sup>17</sup> Ibid.

<sup>18</sup> Ibid.

## **Part 3**

### **2005 and Beyond**

*I've done it, I've done it! Guess what I've done! Invented a light that plugs into the sun. The sun is bright enough, the bulb is strong enough, but, oh, there's only one thing wrong...the cord ain't long enough.*

—Shel Silverstein

Joint Vision 2010 states that the American people will expect nothing less than a victory in any engagement.<sup>1</sup> And the people also expect the military to be more efficient in protecting lives and resources while accomplishing the mission successfully.<sup>2</sup> JV 2010 provides a basic guideline upon which to base military doctrine. Doctrine for the AE system is still in the process of being written. It will be an operational framework for AE, with additional components to address the tactical elements. The impact of JV 2010 asserts the importance of readiness training and a highly qualified force, supporting the thesis of this paper. A highly qualified and competent AE crewmember must be informed, educated, and trained in all facets of readiness to include force protection, the strategic environment, LOAC, and the Geneva Conventions. Lack of training in these areas finds the AE crewmember less than 100% prepared and ready to meet their mission responsibilities.

Education is a primary element in preparing Aeromedical crews to face a real threat to their safety and security system that has prevailed since 1949. This can be partially met through Smiths' nine-step approach to a successful law of armed conflict teaching program.<sup>3</sup> Smith

states, "...Air Force personnel must be well-prepared and knowledgeable of the requirements of law before deployment."<sup>4</sup> The non-medical combatant should be well informed of the types of MOOTW that we find ourselves involved in, and the application of these to LOAC and GC. As the author of this paper learned holding a Geneva Convention card does not necessarily ensure compliance by all parties.

To prepare for future conflicts, regardless of actor or war typologies, the AE crewmember must be better educated and trained. To do this not only requires the annual LOAC training, but perhaps an interactive computer based program that will educate non-combatant personnel concerning the nature and character of transnational and other non-state actors, as well as state actors, such as those presented in lecture at Air Command and Staff . This can include a comprehensive education program addressing the types of international and non-international conflicts faced by the US and its allies and their relationship to the LOAC and GC. This would enable the medical non-combatants to deploy throughout the world with comprehensive based character knowledge and background of the players involved and the potential threats. This allows for personal mental preparation and force protection.

If budgetary constraints and time don't afford AE crewmembers the opportunity to attend the training at Fairchild, then a standardized program should be developed to implement in every squadron. It should contain all the necessary elements of SERE, to include education of our current strategic environment. SERE training is needed of today, and in the future due to regional or State centered threats, transnational threats, failed states, and weapons of mass destruction.

One approach to SERE training is developing a standardized program that can be taken on the road to individual squadrons or regionally located squadrons to provide the resistance and

escape training not currently afforded through flight school for AE crewmembers. This could be accomplished on a four-year cycle, with active and reserve AE squadrons training together over a week. This allows the reserve AE crewmember the ability to utilize a week of their annual tour to accomplish this training and possible other four-year cycle training during their second week of annual tour. Yearly refresher SERE and water survival training can be accomplished under a standardized guideline and instruction, at the squadron level with local life support personnel or an interactive computer based instruction program.

Hours and dollars are spent in training for quality assurance and mentoring programs, why not for a program which would provide for personal force protection and 100% readiness capabilities. Failing to address this and other readiness concerns, may one day find military leadership accounting to Congress, the American Public, and Family members, why it was not feasible to train our medical non-combatants in ways that would enhance their opportunities for survival and a quality lifestyle.

SERE is an element of force protection for the AE personnel. Our medical assets are valuable and deserve the best readiness training available. It is a disservice to our people not to have them informed of all facets of the situation, which potentially confronts them.

### **Notes**

<sup>1</sup> Joint Chiefs of Staff, Joint Vision 2010, (1996), p.8.

<sup>2</sup> Ibid.

<sup>3</sup> Major Bruce T. Smith, ANG. "Air Force Medical Personnel and the Law of Armed Conflict.", *The Air Force Law Review*, Vol. 37, (Air Force Judge Advocate General School, Maxwell, AFB, AL, 1994), 239-251. See appendix C for a copy of the suggested step by step approaches.

<sup>4</sup> Ibid., 25.

## Appendix A

### Parthenon



Figure 1 AFMS Parthenon

## Appendix B

### A Very Personal Story of Vietnam

At the 1st Cav reunion Dr Hal Kushner, who served with 1/9 Cav, 1 Cav Div, in Vietnam, told the story of his service in Vietnam and his horrible ordeals, extreme pain and suffering and unflinching loyalty and honor to the United States Army and our country.

The words of Dr Hal Kushner:

I want you to know that I don't do this often. I was captured 2 Dec. 1967, and returned to American control on 16 Mar. 1973. For those of you good at arithmetic 1931 days. Thus it has been 32 years since capture and 26 years since my return. I have given a lot of talks, about medicine, about ophthalmology, even about the D Day Invasion as I was privileged to go to Normandy and witness the 50th anniversary of the invasion in Jun. 1944. But not about my captivity. I don't ride in parades; I don't open shopping centers; I don't give interviews and talks about it. I have tried very hard NOT to be a professional PW. My philosophy has always been to look forward, not backward, to consider the future rather than the past. That's a helluva thing to say at a reunion, I guess.

In 26 years, I've given only two interviews and two talks. One to my hometown newspaper, one to the Washington Post in 1973, and a talk at Ft. Benning in 1991 and to the Military Flight Surgeons in 1993. I've refused 1,000 invitations to speak about my experiences. But you don't say no to the 1-9th, and you don't say no to your commander. COL Bob Nevins and COL Pete Booth asked me to do this and so I said yes sir and prepared the talk. It will probably be my last one.

I was a 26-year-old young doctor, just finished 9 years of education, college at the University of North Carolina, med school at Medical College of VA, a young wife and 3 year old daughter. I interned at the hospital in which I was born, Tripler Army Med Center in Honolulu, HI. While there, I was removed from my internship and spent most of my time doing orthopedic operations on wounded soldiers and Marines. We were getting hundreds of wounded GIs there, and filled the hospital. After the hospital was filled, we created tents on the grounds and continued receiving air evac patients. So I knew what was happening in Vietnam. I decided that I wanted to be a flight surgeon. I had a private pilot's license and was interested in aviation. So after my internship at Tripler, I went to Ft. Rucker and to Pensacola and through the Army and Navy's aviation medicine program and then deployed to Vietnam.

While in basic training and my E&E course, they told us that as Doctors, we didn't have to worry about being captured. Doctors and nurses they said were not PWs, they were detained

under the Geneva Convention. If they treated us as PWs, we should show our Geneva Convention cards and leave. It was supposed to be a joke and it was pretty funny at the time.

I arrived in Vietnam in Aug.1967 and went to An Khe. I was told that the Div. needed two flight surgeons; one to be the div. flight surgeon at An Khe in the rear and the other to be surgeon for the 1-9th a unit actively involved with the enemy. I volunteered for the 1-9th. The man before me, CPT Claire Shene had been killed and the dispensary was named the Claire Shene Memorial Dispensary. Like many flight surgeons, I flew on combat missions in helicopters, enough to have earned three air medals and one of my medics, SSG Jim Zeiler used to warn me: "Doc, you better be careful. We'll be renaming that dispensary, the K&S Memorial Dispensary."

I was captured on 2 Dec., 1967 and held for five and a half years until 16 Mar.,1973. I have never regretted the decision that I made that Aug. to be the 1-9th flight surgeon. Such is the honor and esteem that I hold the squadron. I am proud of the time I was the squadron's flight surgeon.

On 30 Nov.1967, I went to Chu Lai with MAJ Steve Porcella, WO-1 Giff Bedworth and SGT McKeckney, the crew chief of our UH-1H. I gave a talk to a troop at Chu Lai on the dangers of night flying. The weather was horrible, rainy and windy, and I asked MAJ Porcella, the A/C commander, if we could spend the night and wait out the weather. He said, "Our mission is not so important but we have to get the A/C back." I'll never forget the devotion to duty of this young officer; it cost him his life.

While flying from Chu Lai to LZ Two Bits, I thought we had flown west of Hwy. 1, which would be off course. I asked Steve if we had drifted west. He called the ATC at Duc Pho and asked them to find him. The operator at Duc Pho said that he had turned on his radar off at 2100. He said, "Do you want me to turn it on and find you?" MAJ Porcella replied "Roj" and that was the last thing he ever said. The next thing I knew I was recovering from unconsciousness in a burning helicopter which seemed to be upside down. I tried to unbuckle my seat belt and couldn't use my left arm. I finally managed to get unbuckled and immediately dropped and almost broke my neck. My helmet was plugged into commo and the wire held me as I dropped out of the seat which was inverted. The helicopter was burning. Poor MAJ Porcella was crushed against the instrument panel and either unconscious or dead.

Bedworth was thrown, still strapped in his seat out of the chopper. His right anklebones were fractured and sticking through the nylon of his boot. SGT Mac was unhurt but thrown clear and unconscious. I tried to free Porcella by cutting his seatbelt and moving him. However, I was unable to. The chopper burned up and I suffered burns on my hands and buttocks and had my pants burned off. While trying to free Porcella, some of the M-60 rounds cooked off and I took a round through the left shoulder and neck. My left wrist and left collarbone were broken in the crash, and I lost or broke 7 upper teeth.

Well, after we assessed the situation-we had no food or water, no flares, no first aid kit or survival gear. We had two 38 pistols and 12 rounds, one seriously wounded WO co-pilot, a moderately wounded doctor, and an unhurt crew chief. We thought we were close to Duc Pho and Hwy 1 and close to friendlies. Bedworth and I decided to send Mac for help at first light. We never saw him again.

Later, 6 years later, COL Nevins told me that SGT Mac had been found about 10 miles from the crash site, shot and submerged in a rice paddy. So on that night of 30 Nov.1967 I splinted Bedworth's leg, with tree branches, made a lean-to from the door of the chopper, and we sat in the rain for three days and nights. We just sat there. We drank rainwater. On the third

morning, he died. We could hear choppers hovering over our crash site and I fired most of the rounds from our 38's trying to signal them, but cloud cover was so heavy and the weather so bad, they never found us. I took the compass from the burned out helicopter and tried to go down the mountain towards the east and, I believed friendlies. My glasses were broken or lost in the crash and I couldn't see well: the trail was slippery and I fell on rocks in a creek bed and cracked a couple of ribs. I had my left arm splinted to my body with my army belt. My pants were in tatters and burned. I had broken teeth and a wound in my shoulder. I hadn't eaten or drunk anything but rainwater for three days. I looked and felt like hell. One of the cruel ironies of my life, you know how we all play the what if games, what if I hadn't done this or that, well, when I finally reached the bottom of the mountain, I estimated 4 hours after first light, the weather cleared and I saw choppers hovering over the top. I knew I couldn't make it up the mountain, and had to take my chances. But if I had only waited another 4 hours.

I started walking up the trail and saw a man working in a rice paddy. He came over and said Dai-wi, Bac-si- CPT Doctor. He took me to a little hooch, sat me down and gave me a can of sweetened condensed milk and a C-ration can, can opener and spoon. This stuff was like pudding and it billowed out of the can and was the best tasting stuff I ever had. I felt very safe at that point. One minute later, my host led a squad of 14 VC with two women and 12 rifles came upon me. The squad leader said, "Surrenda no kill." He put his hands in the air and I couldn't because my left arm was tied to my body. He shot me with an M2 carbine and wounded me again in the neck. After I was apprehended, I showed my captors my Geneva Convention card, white with a red cross. He tore it up. He took my dogtags and medallion which had a St. Christopher's (medal) on one side and a Star of David on the other, which my dad had given me before leaving. They tied me with commo wire in a duck wing position, took my boots and marched me mostly at night for about 30 days. The first day they took me to a cave, stripped my fatigue jacket off my back, tied me to a door and a teenage boy beat me with a bamboo rod. I was told his parents were killed by American bombs. We rested by day, and marched by night. I walked on rice paddy dikes, and couldn't see a thing. They would strike these little homemade lighters and by the sparks they made, see four or five steps. I was always falling off the dikes into the rice paddy water and had to be pulled back up. It was rough. On the way, I saw men, women and kids in tiger cages, and bamboo jails. I was taken to a camp, which must have been a medical facility as my wound was festering and full of maggots and I was sick. A woman heated up a rifle-cleaning rod and gave me a bamboo stick to bite on. She cauterized my through and through wound with the cleaning rod and I almost passed out with pain. She then dressed the wound with mercurochrome and gave me two aspirin. I thought, what else can they do to me. I was to find out. After walking for about a month through plains, then jungles and mountains, always west, they took me to a camp. I had been expecting a PW camp like a stalag with Hogan's Heroes; barbed wire, search lights, nice guards and red cross packages-and a hospital where I could work as a doctor. They took me to a darkened hut with an oriental prisoner who was not American. I didn't know whether he was Vietnamese, Cambodian, Laotian or Chinese. He spoke no English and was dying of TB. He was emaciated, weak, sick and coughed all day and night. I spent two days there and an English speaking Vietnamese officer came with a portable tape recorder and asked me to make a statement against the war. I told him that I would rather die than speak against my country. His words which were unforgettable and if I ever write a book, will be the title. He said, "You will find that dying is very easy; living, living is the difficult thing."

A few days later, in a driving rain, we started the final trek to camp. I was tied again, without boots, and we ascended higher and higher in the mountains. I was weak and asked to stop often and rest. We ate a little rice, which the guards cooked. We actually needed ropes to traverse some of the steep rocks. Finally, we got to PW camp one. There were four American servicemen there, two from the US and two from Puerto Rico. Three were Marines and one in the Army. These guys looked horrible. They wore black PJs, were scrawny with bad skin and teeth and beards and matted hair. The camp also had about 15 ARVNPs who were held separately, across a bamboo fence. The camp was just a row of hootches made of bamboo with elephant grass roofs around a creek, with a hole in the ground for a latrine. This was the first of five camps we lived in the South-all depressingly similar, although sometimes we had a separate building for a kitchen and sometimes we were able to pipe in water thru bamboo pipes from a nearby stream.

I asked one of the Marines, the man captured longest and the leader, if escape was possible. He told me that he and a special forces CPT had tried to escape the year before and the CPT had been beaten to death, while he had been put in stocks for 90 days, having to defecate in his hands and throw it away from him or lie in it. The next day I was called before the camp commander and chastised and yelled at for suggesting escape. My fellow PW then told me never to say anything to him that I didn't want revealed, because the Vietnamese controlled his mind. I threatened to kill him for informing on me. He just smiled and said I would learn. Our captors promised us that if we made progress and understood the evils of the war they would release us. And the next day, they released the two Puerto Ricans and 14 ARVNPs PWs. The people released wore red sashes and gave anti-war speeches. Just before the release, they brought in another 7 American PWs from the 196th Light Bde who were captured in the TET offensive of '68. I managed to write our names, ranks and serial numbers on a piece of paper and slip it to one of the PRs who was released. They transported the information home and in Mar. 1968 our families learned we had been captured alive.

We were held in a series of jungle camps from Jan. 1968 to Feb. 1971. At this time, conditions were so bad and we were doing so poorly, that they decided to move us to North Vietnam. They moved 12 of us. In all, 27 Americans had come through the camp. Five had been released and ten had died. They died of their wounds, disease, malnutrition and starvation. One was shot while trying to escape. All but one died in my arms after a lingering, terrible illness. Five West German nurses in a neutral nursing organization, called the Knights of Malta, similar to our own Red Cross, had been picked up (I always thought by mistake) by the VC in the spring of '69. Three of them died and the other two were taken to North Vietnam in 1969 and held until the end of the war.

The twelve who made it were moved to North Vietnam on foot. The fastest group, of which I was one, made it in 57 days. The slowest group took about 180 days. It was about 900km. We walked thru Laos and Cambodia to the Ho Chi Minh trail and then up the trail across the DMZ until Vinh. At Vinh, we took a train 180 miles to Hanoi in about 18 hours. We traveled with thousands of ARVN PWs who had been captured in Lam Song 719, an ARVN incursion into Laos in 1971.

Once in Hanoi, we stayed in an old French prison called The Citadel or as we said, The Plantation until Christmas '72 when the X-mas bombing destroyed Hanoi. Then we were moved to the Hoa Lo or Hanoi Hilton for about three months. The peace was signed in Jan., '73 and I came home on Mar. 16 with the fourth group. In the North we were in a rough jail. There was a bucket in the windowless, cement room used as a latrine. An electric bulb was on 24 hours. We

got a piece of bread and a cup of pumpkin soup each day and three cups of hot water. We slept on pallets of wood and wore PJs and sandals and got three tailor made cigarettes per day. We dry shaved and bathed with a bucket from a well twice per week, got out of the cell to carry our latrine bucket daily.

Towards the end, they let us exercise. There were no letters or packages for us from the south, but I understood some of the pilots who had been there awhile got some things. In the summer, it was 120 in the cell and they gave us little bamboo fans. But there were officers and a rank structure and commo done through a tap code on the walls. No one died. It was hard duty, but not the grim struggle for survival which characterized daily life in the camps in the south. In the north, I knew I would survive. In the south, we often wanted to die. I knew that when they ordered us north, I would make it. In the south, each day was a struggle for survival. There were between three and twenty-four PWs at all times. We ate three coffee cups of rice per day. In the rainy season, the ration was cut to two cups. I'm not talking about nice white rice, Uncle Ben's. I'm talking about rice that was red, rotten, and eaten out by bugs and rats, cached for years, shot through with rat feces and weevils. We arose at 4, cooked rice on wood ovens made of mud. We couldn't burn a fire in the daytime or at night unless the flames and smoke were hidden, so we had these ovens constructed of mud which covered the fire and tunnels which carried the smoke away. We did slave labor during the day, gathering wood, carrying rice, building hooches, or going for manioc, a starchy tuberous plant like a potato. The Vietnamese had chickens and canned food. We never got supplements unless we were close to dying then maybe some canned sardines or milk. We died from lack of protein and calories. We swelled up with what is called hungry edema and beriberi. We had terrible skin disease, dysentery, and malaria. Our compound was littered with piles of human excrement because people were just too sick or weak to make it to the latrine.

We slept on one large pallet of bamboo. So the sick vomited and defecated and urinated on the bed and his neighbor. For the first two years, we had no shoes, clothes, mosquito nets or blankets. Later, in late '69, we got sandals, rice sacks for blankets, and a set of clothes. We nursed each other and helped each other, but we also fought and bickered. In a PW situation the best and the worst come out. Any little flaw transforms itself into a glaring lack. The strong can rule the weak. There is no law and no threat of retribution. I can report to you that the majority of the time, the Americans stuck together, helped each other and the strong helped the weak. But there were exceptions and sometimes the stronger took advantage of the weaker ones. There was no organization, no rank structure. The VC forbid the men from calling me Doc, and made me the latrine orderly to break down rank structure. I was officially forbidden from practicing medicine. But I hoarded medicine, had the men fake malaria attacks and dysentery so we could acquire medicine and keep it until we needed it. Otherwise, it might not come. I tried to advise the men about sanitary conditions, about nutrition and to keep clean, active and eat everything we could; rats, bugs, leaves, etc. We had some old rusty razor blades, and I did minor surgery, lancing boils, removing foreign bodies, etc. with them, but nothing major.

At one time, in the summer of '68, I was offered the chance to work in a VC hospital and receive a higher ration. The NVA Political officer, who made the offer and was there to indoctrinate us, said it had been done in WW II. I didn't believe him and didn't want to do it anyway, so I refused and took my chances. Later, upon return, I learned that American Army doctors in Europe in WW II, had indeed worked in hospitals treating German soldiers. But I'm glad now I did what I did. We had a 1st Sergeant who had been in Korea and in WW II. He died in the fall of '68 and we were forbidden from calling him "Top". The VC broke him fast. I was

not allowed to practice medicine unless a man was 30 minutes away from dying, then they came down with their little bottles of medicine and said "Cure him!" At one point we were all dying of dysentery and I agreed to sign a propaganda statement in return for chloromycetin, a strong antibiotic, to treat our sick. Most of us were seriously ill, although, a few never got sick, maintained their health and their weight. I never figured it out.

When a man died, we buried him in a bamboo coffin and said some words over his grave and marked it with a pile of rocks. I was forced to sign a death certificate in Vietnamese. I did this 13 times. The worst period was the fall of '68. We lost five men between Sept. and Christmas. Shortly before the end of Nov., I thought I was going to lose my mind. All of these fine young strong men were dying. It would have been so easy to live, just nutrition, fluids, and antibiotics. I knew what to do, but had no means to help them. I was depressed and didn't care whether I lived or died myself.

At this time, we were simply starving to death. As an example of how crazy we were, we decided to kill the camp commander's cat. Several of us killed it, and skinned it. We cut off its head and paws and it dressed out to about three pounds. We were preparing to boil it when one of the guards came down and asked us what was going on. We told him we had killed a weasel by throwing a rock. The guards raised chickens and the chickens were always being attacked by weasels. Well, the guard, who was a Montagnard, an aborigine, found the feet, and knew it was the cat. The situation became very serious. The guards and cadre were mustered...it was about 3 am. The prisoners were lined up and a Marine and I were singled out to be beaten. He was almost beaten to death. I was beaten badly, tied up with commo wire very tightly (I thought my hands would fall off and knew I would never do surgery again) for over a day. I had to bury the cat. And I was disappointed I didn't get to eat it. That's how crazy I was.

Shortly thereafter, the Marine who had been beaten so badly died. He didn't have to. He simply gave up, like so many. Marty Seligman, a professor of psychology at University of Pennsylvania has written a book about these feelings called Learned Helplessness and Death. The Marine simply lay on his bamboo bed, refused to eat, wash or get up and died. So many did this. We tried to force them to eat, and to be active, but nothing worked. It was just too hard. This Marine wavered in and out of coma for about two weeks. It was around Thanksgiving, the end of November. The rains had been monstrous and our compound was a muddy morass littered with piles of feces. David Harker of Lynchburg, VA and I sat up with him all night. He hadn't spoken coherently for over a week. Suddenly, he opened his eyes and looked right at me. He said, "Mom, dad..I love you very much. Box 10, Dubberly, Louisiana." That was Nov., '68.

We all escaped the camp in the south. Five were released as propaganda gestures. Ten Americans and three Germans died and twelve Americans and two Germans made it back. I am the only PW who was captured before the end of '67 to survive that camp. I came back Mar. 16, 1973 and stayed in the hospital in Valley Forge, PA for a month getting fixed up with several operations and then went on convalescent leave. The first thing I did was go to Dubberly, LA and see the Marine's father. His parents had divorced while he was captured. I went to see five of the families of those that died and called the others on the phone.

It was a terrible experience, but there is some good to come from it. I learned a lot. I learned about the human spirit. I learned about confidence in yourself. I learned about loyalty to your country and its ideals and to your friends and comrades. No task would ever be too hard again. I had renewed respect for what we have and swore to learn my country's history in depth (I have done it) and to try to contribute to my community and set an example for my children and employees.

I stayed on active duty until '77 when I was honorably discharged and entered the reserve from which I retired an as O-6 in '86. I have a busy medical practice down in Florida and been remarkably successful. I am active in my community in a number of ways and despite being drenched with Agent Orange a number of times and having some organs removed, have enjoyed great health. Except for dome arthritis and prostate trouble, I'm doing great. So I was lucky..very lucky and I'm so thankful for that. I'm thankful for my life and I have no bitterness. I feel so fortunate to have survived and flourished when so many braver, stronger and better trained men did not.

## **Appendix C**

### **SUGGESTED APPROACH TO TEACHING THE LAW OF ARMED CONFLICT**

Major Bruce Smith, ANG (rewritten from his article)

The following is a suggested step-by-step approach to a successful law of armed conflict teaching program.

**STEP 1:** Be prepared. Read and become familiar with key sources of the law. Footnote four contains a list of references your medical law of armed conflict library should contain.

**STEP 2:** Create a deskbook. Obtain one or two large, three-ring binders to hold your medical law of armed conflict materials, plus crossfeed information, briefings, and correspondence.

**STEP 3:** Learn from others. Visit the wing inspector's office (CVI) and get copies of inspection reports from medical law of armed conflict inspections of other units. Profit from the mistakes of others. Find out what worked and what did not work at other wings.

**STEP 4:** Solicit crossfeed information. Makes contact with your counterpart at the various levels of your chain of command, including: major command, numbered air force, and other wing.

**STEP 5:** Prepare a marketing strategy. By now you have gathered a sufficient quantity of academic information-but you need to consider how to present the information in an interesting, appealing manner. You need not feel tied to the standard military briefing format. Remember your audience, too. Tailor you presentation to medical personnel. Toward the end, Air Force Pamphlet (AFP) 169-10, Attachment 1 (5 January 1987), contain a teaching outline of the essential law of armed conflict basics that should to be presented to medical and nonmedical personnel. Another idea is to create "real world" scenarios for use in your hospital's continuing Medical Readiness Training. Use other judge advocates, as "role players" in the field in presenting legal issues for resolution. Also, consider a multimedia approach. Elements of the spoken word, graphics, and video make an effective presentation. Obtain USAF Film 38646, Geneva Conventions and Medical Personnel, from your audio/visual detachment. Base supply might have poster-board and ink products so you can create "self-help" graphics. You might consider reproducing the internationally recognized symbols for medical personnel and other protected places contained in AFP 110-34. In sum, you are only limited by your imagination!

**STEP 6:** Schedule your briefings. Contact the hospital commander or first sergeant and find out when the next commander's call or readiness training exercise occurs. Get your medical law of armed conflict program on the agenda.

**STEP 7:** Practice what you preach. In addition to briefings to medical personnel, find ways to put your program into action during wing exercises. Coordination between the wing commander, staff judge advocate, hospital commander, and wing inspector is a must. Enlist judge advocates from the legal office or area defense counsel's office to "role Play." Build violations of the law into the exercise script, together with all the other taskings created by the CVI staff. Include issues such as "misuse of the red cross," "injured enemy pilot," "raids on a medical facility," etc. Monitor to see if medical personnel recognize and report violations. Also consider "spot testing" of medical personnel with short, written tests in the field. These are excellent feedback tools to help you determine if your briefings are getting through to your audience.

**STEP 8:** Keep important players in the loop. Create a law of armed conflict deskbook for use in the wing command post or battle staff. At the very least, this deskbook should include talking papers on medical law or armed conflict issues, reporting requirements, and key telephone numbers. The on-duty judge advocate assigned to the command post or battle staff must be armed with the medical law of armed conflict deskbook you created in step 2.

**STEP 9:** Record and evaluate. Make sure you note all medical law briefings and exercises in your deskbook. Also, note your test results to see if your presentations are getting through. Alter your teaching methods accordingly.

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